Reprinted from the AMERICAN JOURNAL OF SURGERY, April, 1913.

BRIEF NOTES IN PROSTATIC SURGERY.

1. ON THE EMPLOYMENT OF PACKINGS TO PREVENT HEMORRHAGE AFTER SUPRAPUBIC PROSTATECTOMY.
2. ON THE ADMISSIBILITY OF MASSAGE IN ACUTE SUPPURATIVE PROSTATITIS.
3. AN ADDITION TO THE DIAGNOSTICS OF CALCULOUS PROSTATITIS.

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1. *The Employment of Packings to Prevent Hemorrhage after Suprapubic Prostatectomy.*

Probably most surgeons who practice suprapubic prostatectomy introduce one or two gauze packings into the prostatic pouch to control bleeding; but some of them, following Freyer, employ no hemostasis other than by a hot irrigation.

Single experiences often determine a surgeon in one or another method or detail of technique. A single, almost tragic, experience has determined me always to insert a very careful tamponade after suprapubic prostatectomy:

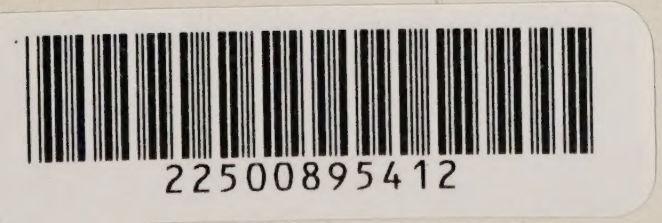
—— Smith, a tall, vigorous and robust car-driver, was referred by Dr. Adolph Schoen to my service in the Philanthropin Hosiptal in May, 1912, suffering with vesical calculi, cystitis and a very large, obstructing prostate. I removed three calculi suprapubically. Twelve days later, when the cystitis had abated and the wound was granulating, I enucleated the adenomatous prostate through the same opening. Nitrous oxide narcosis was employed, which may have contributed to the later development (?). After irrigation with a hot saline solution, two gauze packings were introduced into the prostatic cavity, and when the patient was taken from the operating table all bleeding had

apparently ceased and his general condition was excellent. Less than an hour later, when I was finishing another operation, a nurse reported to me that Mr. Smith's pulse had become very weak and his dressings were soaked with blood. He was, indeed, almost exsanguinated. After removing an astonishing quantity of clotted blood from the bladder, manually and by irrigation, I tamponned the prostatic wound and the bladder itself very thoroughly and applied a sand-bag over the dressing. Thereafter there was no bleeding, and the patient made a good recovery.

II. *The Occasional Admissibility of Massage in Acute Suppurative Prostatitis.*

We are accustomed to regard prostatic massage as a treatment suited only for chronic and residual conditions; and the rule is a wise one to avoid manipulation of the organ when it is acutely inflamed (indeed, I have seen an epididymitis develop immediately after a too vigorous rectal palpation of the prostate). But like many other rules, this one should sometimes be ignored.

In 1908 I treated a young man for an acute posterior urethritis and prostato-cystitis—his first gonorrheal infection. He had fever, pain on defecation, and marked vesical tenesmus, was obliged to urinate every few minutes, and his urine was uniformly purulent throughout. Daily irrigations of the urethra and bladder, continued for nearly two weeks, effected scant improvement in the symptoms or in the appearance of the urine. I was about to institute more frequent irrigations when it occurred to me to try, first, the effect of gently expressing the contents of the soft, abnormally sensitive prostate. The first massage, cautiously undertaken, evacuated a large amount of brownish-yellow pus, and was followed by an immediate marked improvement in the subjective symptoms. After a few daily massages, the pain, tenesmus and fever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ceased entirely; at the end of a week, micturition was at three-hourly intervals and only twice at night, the second portion of the urine was clear and albumin-free, and the pus expressed from the now much less sensitive prostate was scantier and thinner. The patient made a complete recovery, symptomically and bacteriologically, and in the five years that have since elapsed he has had no signs of recurrence.

Here, then, is a case of acute, gonorrheal, suppurative prostatitis, in which massage not only promptly relieved the distressing symptoms but also, probably, saved the patient from the development of a prostatic abscess.

"If, then, in most cases of acute gonorrheal prostatitis a single massage may be followed by disastrous results, and in a few cases massage is the treatment that should be employed, how are these latter to be recognized? To set up, as nearly as possible, a specific indication: if in a case of gonorrheal urethritis there develop symptoms of prostatitis or (and) cystitis (for in these cases the sometimes uniformly turbid urine gives the impression of a cystitis) and if frequent irrigation of the bladder and urethra does not effect a clearing of the urine and diminution in the frequency of micturition, insert the finger into the rectum and gently compress (slightly massaging) the prostate —selecting, if there be such, the most prominent or softest area. If pus then escapes from the urethra the indication for massage is established.

"Massage in these cases is scarcely more painful than is massage of the non-infected gland. Nevertheless, it should be conducted with great gentleness at first; as the tolerance of the gland is learned greater force may be used, if needed. This massage should be performed daily, and followed by irrigation. If the pus is considerable in amount (and it is apt to be), and reaccumulates rapidly, two treatments a day may be desirable for a short time. Within a week the amount of pus expressed will be markedly diminished, the urine will be much clearer and the subjective symptoms will have subsided. In two to four weeks—the massage mean-

Acutely, I cured by massage a case of suppurative of the prostate (gonorrheal) in which ejaculation seemed imminent. The bladder & the urethra in that it sometimes produces an epididymitis.

while at longer intervals—no pus will be seen in the prostatic fluid expressed and, under continued treatment, gonococci and pus cells disappear.

"We are prepared for the criticism that these cases would get well under the usually employed conservative treatment by recumbency, internal medication, etc.; and we are equally prepared to dispute it. Indeed, we are satisfied that this type of prostatitis (in which the acini are probably loaded with pus and in which perhaps minute abscesses have also formed), unless managed by massage, passes on to the development of an abscess.—W. M. B." *

III. *An Addition to the Diagnostics of Calculous Prostatitis.*

I have elsewhere recorded,** with illustrative cases, two data diagnostic of prostatic calculi, and since the symptology of this condition is scant and dealt with meagerly in our text-books and monographs, I would repeat them in this connection. One of these data is a simple physical deduction, and the other is an almost equally obvious clinical observation.

1. If a radiograph of the *unemptied* bladder, exposed with the patient in the level supine or reversed Trendelenburg position, shows a shadow or group of shadows in the region of the neck of the bladder, and a second radiograph, exposed with the patient in the Trendelenburg position and the *x*-rays passing in the same relative direction, shows the shadow in the same place as before, the stone or stones are fixed in the prostate or the prostatic urethra or in a diverticulum behind the prostate.

I suggest to radiographists this technique in order to differentiate vesical from prostatic calculi.

2. The absence, for a long period of time, of all signs of local infection in a case of purulent prostatitis, is strongly suggestive of a calculous etiology.

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* Editorial, American Journal of Surgery, May, 1911.
** Medical Review of Reviews, February, 1913.

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